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ABSTRACT

Homelessness is a growing problem in the midst of relative prosperity. However, as the problem persists, the public may be becoming increasingly less compassionate to the homeless and annoyed by the problem. Although it is difficult to determine how many people are homeless, the most widely circulated estimate puts their number at about 600,000. Single men, including the chronically mentally ill, make up the vast majority of the homeless population; families with children probably account for about 15 percent of homeless people. Spotty work histories, deficient education, and very low incomes present barriers to the self-sufficiency of homeless persons. Substance abuse and criminal records are more common among homeless singles than in homeless families. A large contributing factor to the problem of homelessness is a nationwide shortage of affordable rental units for low-income households. The loss of most single room occupancy dwellings as well as drug abuse are also major contributing factors to homelessness. The presence of the chronically mentally ill living on the streets calls for a reexamination of the nation's mental health policies, which have for 30 years called for deinstitutionalization. The high cost of aiding homeless people amidst other pressing unmet needs presents formidable obstacles to expanding assistance to this population. In addition to a major initial investment, about \$6 billion would be needed annually to provide job training, employment, and support services as well as hospitalization of the seriously mentally ill. (An appendix describes programs funded under the Stewart B. McKinney Homeless Assistance Act. Thirty-eight endnotes are included.) (KC)

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The Paradox of Homelessness in America

**Sar A. Levitan
Susan Schillmoeller**

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SUMMARY

Homelessness is a festering problem gnawing at the American conscience. Homelessness in the midst of affluence and relatively low unemployment runs counter to public expectations that minimal, yet adequate, shelter be available to all Americans. However, as the problem persists, it appears that the public is becoming increasingly inured to homelessness, and its persistence is provoking more annoyance than compassion.

Precise statistics on the homeless do not exist. In 1990 the United States Census Bureau attempted a head count, but conceded that many went uncounted. By their very nature many homeless escape data collection efforts, but the most widely cited estimate puts their number at about 600,000. Single men, including the chronically mentally ill, make up the vast majority of the homeless population. Families with children probably account for about 15 percent of the homeless. Spotty work histories, deficient education and average incomes less than a fourth of the federal poverty level present barriers to their economic self-sufficiency. Homeless families fare somewhat better than single men. The incidence of substance abuse and criminal records that characterizes many homeless singles is less prevalent among members of homeless families.

In 1987 there was a nationwide shortage of 3.6 million affordable rental units for low-income households. The loss of single room occupancy (SRO) dwellings and other affordable housing, and substance abuse are major contributing factors to homelessness. SROs were the mainstay in the housing market for poor single men and the mentally ill. With the decline in the affordable housing supply, many former occupants ended up on the streets. During the 1980s annual federal outlays for housing continued to rise, but at a sharply reduced level of new commitments.

The presence of the chronically mentally ill living on the streets calls for a reexamination of the nation's mental health policies. Since the 1950s new drug treatments and an extension of civil liberties paved the way for the release of the mentally ill from "snake pit" asylums, but mental health facilities and a fragmented social service delivery system have not provided the community-based support needed by the mentally ill. It has become increasingly clear that for a minority, mental hospitals are the best and indeed most compassionate option. The challenge is to balance minimally adequate asylum and treatment with legal safeguards to protect civil liberties, but the current legal environment and the high cost of institutional care present severe obstacles, preventing implementation in the near future.

The high cost of aiding the homeless amidst other pressing unmet needs presents formidable obstacles to expanding assistance to the homeless. A conservative estimate suggests that in addition to a major initial investment, nearly \$6 billion would be needed annually to provide rental assistance, job training, employment and support services to the homeless, as well as hospitalization of the seriously mentally ill. In fiscal 1990 federal direct appropriations to provide emergency shelter, services, and food stamps for the homeless amounted to about \$600 million. For 1991 the Bush administration proposed to boost this amount to \$749 million, still far short of what is needed to make a significant dent in the problem. The 101st Congress has no comprehensive package in the works, and the fragmented administrative structure ensures that current expenditures do not provide optimal assistance. It seems that homelessness will continue well into the 1990s.

AN AGE-OLD PHENOMENON

Homeless transients living on the margins of society have existed throughout history. In colonial America poor laws distinguished between the "deserving" homeless, who received meager relief, and the able-bodied whose circumstances were presumably due to deviant behavior and were therefore not entitled to "handouts." Local poorhouses and almshouses provided for the frail, the elderly and orphans, and asylums housed the mentally ill. Vagrancy laws removed the homeless out of sight by jailing or removing beggars from the area, or forcing them to work. During the 1800s most large towns had workhouses, yet few provided productive jobs. Originally intended to provide a "moral treatment" regimen incorporating a disciplined, yet benevolent work ethic, generosity gave way to patient control as asylums became crowded and costs rose. Transient workers, or hoboes, mostly a product of industrialization, could find shelter in the skid row flophouses which became widespread as a market response to a changing economy. These facilities expanded and waned as employment opportunities grew and contracted.

The Great Depression produced a rise in the number of transients, mostly unemployed single men. Government responsibility for the impoverished emerged as persistent mass unemployment shattered beliefs in a link between individual character and destitution. New Deal legislation provided temporary shelters in conservation camps and employed at the peak some 300,000 transient persons.

World War II and the sustained economic growth that followed sharply cut the unemployed transient population. Rising incomes and New Deal social insurance and other welfare programs cushioned the effects of unemployment. According to one estimate the skid row population shrunk by one half between 1950 and 1970. Alcoholic older men accounted for many of the remaining skid row residents. The subsequent rise of homelessness was caused by the declining availability of affordable housing—including single room occupancy (SROs) dwellings, continued deinstitutionalization of the mentally ill, rising substance abuse, the declining real value of welfare benefits, and the sharply reduced earnings of deficiently educated young men. Some of these developments date back to the 1950s, but they became more pronounced in the 1980s.

Today's homeless are unable to obtain poor or marginal housing in the marketplace partly because of the shortfall of affordable housing. With vagrancy and loitering no longer offenses in most communities, the homeless live on the streets or find nightly refuge in shelters supported by pub-

lic, church and other private community organizations. The mentally ill, who before the mid 1950s were housed in institutions, also boosted the number of homeless persons. Mothers accompanied by their children are a new addition to the homeless. Given the diversity of the homeless population, policies addressing homelessness must consider the economic, social and pathological factors contributing to its persistence.

THE ELUSIVE BODY COUNT

Estimating the extent of homelessness is more guesswork than science because the homeless, with no fixed addresses, are difficult to locate and an undetermined proportion may be reluctant to participate in surveys even when found. Any estimate of this population is fraught with complex measurement problems and often based on arbitrary assumptions. At best, whatever estimates are used are only rough magnitudes of the size of the homeless population. The Census Bureau undertook a count of the homeless population at a cost exceeding \$3 million for the 1990 census (to be released next year), but the enumerators counted only the "visible" homeless, leaving significant portions of the homeless uncounted while probably double-counting others. The homeless are not only elusive, but "moving targets" for Census Bureau enumerators.

The Census Bureau count, neither a census nor a sample survey, cannot be regarded as an estimate of the total homeless population because it excludes the isolated and hidden homeless. The Census Bureau intended its count to reveal no more than a ballpark estimate of the homeless population and a "snapshot" of its age, sex, race and location. A few numbers indicate the magnitude of the task. For the 14-hour mostly dead-of-night March 1990 survey, the Bureau hired 22,600 enumerators to count the homeless in 10,600 shelters and 24,000 transportation hubs, emergency rooms, streets, alleys, and parks.¹ But the media questioned the Census estimates, even before they were released. An evaluation financed by the Census Bureau and the City of Los Angeles, released in June 1990, estimated on the basis of preliminary information that the enumerators overlooked 59 to 70 percent of the homeless people in Los Angeles. The Census Bureau countered that the media reports were misleading because they failed to take into account the homeless found in shelters.

The Census Bureau's March 1990 homeless count was the federal government's first attempt at a nationwide count of the homeless. When homelessness first surfaced as

a major issue following the 1981-82 recession, the Department of Housing and Urban Development (HUD) estimated the number of homeless to be between 250,000 and 350,000. Critics charged HUD with downplaying the gravity of the homeless problem because its estimate excluded persons outside central cities and was largely based on the opinions of local officials and shelter workers. Advocacy groups countered with claims of an estimate of two to three million homeless persons based on interviews with local service providers, a source no more reliable than the HUD estimate. The numbers controversy intensified when advocates charged that the findings of the 1990 Census Bureau count would be used to downgrade the seriousness of the homeless problem and result in reduced assistance.

Three additional studies made national estimates of the homeless population. Probably the most careful estimate was prepared by Urban Institute researchers. Based on a national probability sample of 1,704 homeless persons found in shelters and soup kitchens in cities with more than 100,000 people, the Urban Institute analysts estimated that in 1987 the total homeless population numbered about 600,000 persons.² Two additional studies, based on a refinement of the 1983 HUD methodology, placed the number of homeless at the upper limit of the initial estimate—350,000.³

All three studies made assumptions about the ratio of non urban homeless (who were not surveyed) to urban homeless and street persons to those using services. Because there is little solid evidence to support the assumptions, the reliability of these estimates is tenuous. However, they strongly indicate that the two to three million figure—frequently repeated by the media—is far off the mark. Reports that the number of homeless has increased in recent years may be true but solid evidence is lacking.

WHO ARE THE HOMELESS?

Numerous local studies provide data on the homeless. Although the local surveys use different definitions and methods, they suggest that the homeless share many common characteristics. The Urban Institute's national survey reinforces the data found in the local studies.

The duration of homelessness varies widely and recidivism seems to be common. The Urban Institute estimated that half had been homeless for less than a year, and a fifth for more than four years. A 1985-86 Minneapolis survey of 339 homeless in shelters, soup kitchens and drop-in centers

found that 38 percent were homeless for more than two years.⁴

Irregular work habits or lack of recent work experience characterize the homeless. Local surveys found that between 61 and 88 percent of the homeless did not work during the preceding month, and few of those who held jobs were employed full time. Less than a tenth of the homeless in Minneapolis and Ohio worked full time in the month preceding the surveys. The Urban Institute study estimated that only 10 percent had held a steady job during the three months preceding its survey, and half had not had steady employment for over two years.

The homeless tend to be poorly educated. Half did not complete a high school education, double the proportion of the total U.S. adult population. The reduced real earnings of young workers during the past two decades and the decline in the value of the minimum wage contributed to homelessness. A review of 10 homeless studies undertaken in the mid-1980s estimated that the monthly median income of the homeless was about \$100, less than a fourth of the federal poverty threshold for a single person.⁵

The low income of the homeless reflects their work and education histories. Given the extreme penury of the homeless, most are eligible to participate in diverse welfare programs, but few receive benefits. Only a fifth of the homeless received food stamps and a much smaller proportion received cash assistance: some 12 percent received state or local general assistance, four percent obtained federal supplemental security income (designed to aid the poor disabled and old), and five percent received aid to families with dependent children, indicating that at least one of every twenty counted homeless persons had children. Receipt of welfare benefits varies greatly among localities. In Minneapolis, where benefits are generous compared to other areas, over half of the homeless received general assistance.

Three major groups account for the bulk of the homeless: single men, the mentally ill, and families with children. The characteristics of single men and the mentally ill overlap considerably, but the latter constitute a significant subgroup requiring separate discussion. The causes of homelessness and the potential of each group to benefit from housing, rehabilitation and other programs varies.

Single men account for more than three of every four homeless persons. The majority are in their thirties or early forties. They tend to be homeless for long periods. Eighty-

three percent were homeless for more than three months, including more than a fifth who were homeless for more than four years. Drug and alcohol abuse are common as are criminal records. Between a third and two-thirds had been hospitalized for substance dependency or showed symptoms of chronic alcoholism. Between 30 and 50 percent had criminal records.

A history of hospitalization is also common among mentally ill, homeless single persons. Several surveys found that between 19 and 31 percent of the homeless had been hospitalized in a psychiatric institution. Many more may have diagnosable mental illnesses but have never been hospitalized. A study of 530 homeless persons in Baltimore missions, shelters and jails by The Johns Hopkins School of Medicine psychiatrists found that 31 percent of homeless men and 36 percent of the women were diagnosed with a major mental illness such as schizophrenia or manic-depression.⁶ Based on a review of 27 studies published between 1975 and 1987, the U.S. General Accounting Office reported that the chronically mentally ill ranged from 10 to 47 percent of the homeless population.⁷

Families with children make up a small portion of the homeless. A Chicago study found that 9 percent of the homeless were accompanied by spouses, children or other relatives; in Minneapolis families accounted for 19 percent of the homeless. The Urban Institute's survey corroborated these findings, estimating that families accounted for about 16 percent of the homeless, including 8 percent single women with children.⁸ Family break up or violence is a major cause of homelessness. Similarly, runaway or homeless youth are a subset of homeless families. The U.S. Conference of Mayors estimated that they comprise four percent of the total homeless.⁹

The media frequently report that families with children account for one-third of the homeless. This discrepancy may be due to the fact that the media estimates are based on reports from shelters only where families are more likely to be found. Homeless singles more often are found in soup kitchens, drop-in centers and on the streets.

Families tend to be homeless for a shorter period than single persons. Half were homeless for less than a month, 41 percent for less than three months, and 7 percent for more than four years. Members of homeless families are less likely than other homeless groups to have histories of hospitalization for mental disorders, substance abuse or crime. Less than 8 percent of homeless families experienced any of these problems.¹⁰

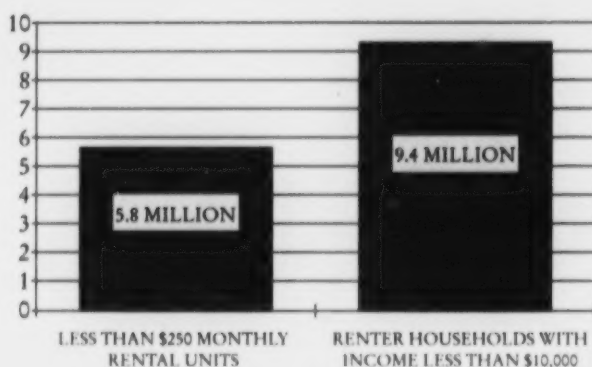
A better understanding of the factors contributing to homelessness might more effectively target federal funding of homeless programs. A national probability survey that could supply useful insights about the homeless and their afflictions would cost at least several million dollars, depending upon the sample size and the details sought. The high cost and the difficulties of obtaining hard data are likely to inhibit the development and implementation of the needed survey.

WHY ARE THEY HOMELESS?

Without belaboring the obvious, the homeless lack stable and permanent housing and the income to pay for it. The homeless also lack supportive ties to relatives or friends, and the fragmented welfare system is ill equipped to cope with the multiple problems that afflict the homeless. Although some homeless persons prefer street living to often dangerous shelters, few would "choose" homelessness if affordable private quarters were available. The inability to compete in the housing market and their isolation from family, friends or access to governmental assistance has pushed some of the poor into homelessness. However, the acute problems faced by the homeless may prevent some from adjusting to stable living conditions even if they could afford to pay rent.

A sharp drop in the 1970s of affordable rental units, defined by HUD as costing 30 percent or less of a household's income, was a significant factor contributing to homelessness in the early 1980s. The Census Bureau's 1970 and 1980 housing surveys conducted for HUD reported that for the 5.8 million renter households with annual incomes of less than \$3,000 in 1970 (10,470 in 1989 dollars) there were potentially available 5.1 million rental units considered affordable—under \$75 a month (262 in 1989 dollars). The shortage became more acute during the 1980s. The median monthly rent for this segment of the population rose during the 1970s by 149 percent compared with the consumer price index increase of 112 percent. The shortage of affordable housing and rising rent burdens persisted during the 1980s. In 1987, the latest year for which national housing data are available, there were 5.8 million units with monthly rents of less \$250 for 9.4 million households with incomes of less than \$10,000 (figure 1). These data may underestimate the shortfall of affordable housing for the poor because as a result of rent controls an undetermined number of low rental units are occupied by nonpoor households. About half of households below the poverty level paid more than 70 percent of their income for rent.¹¹

Figure 1. Poor households faced a shortage of 3.6 million affordable rental units (1987).



Source: U.S. Census Bureau, American Housing Survey, 1987

The factors contributing to a shortage of affordable housing are complex. Housing markets are primarily dominated by local conditions, although they are also influenced by federal policies. Weighing the relative importance of construction and land costs, zoning and building codes, vacancy rates, abandonments, property taxes and rent control requires detailed local data. National housing data, collected by the Census Bureau for HUD, shed little light on the direct relationship between homelessness and local housing conditions. Variations in local homeless populations and housing markets are too important to ignore when considering solutions.

Based on an analysis of homelessness, vacancy rates and rent controls in 50 cities, one analyst argued that rent controls might account for homelessness in some cities. This much publicized but seriously flawed study claimed that the nine cities with rent controls were among the 17 cities with the highest rates of homelessness and vacancy rates in the mid 1980s of 2.6 or less (table 1.) Rates of 3.0 or less are considered to reflect tight housing markets.

TABLE 1. Homelessness, rent control and vacancy rates

City	Homeless rate per 1000 (1983)	Vacancy rate 1983-86
Miami	15.9	7.0
St. Louis	11.6	8.5
*San Francisco	11.5	1.6
Worcester	10.6	3.0
*Los Angeles	10.5	2.2
*Santa Monica	10.2	1.8
*Newark	9.5	2.3

(cont. on page 14)

Table 1. (Continued)

City	Homeless rate per 1000 (1983)	Vacancy rate 1983-86
*Hartford	8.8	2.6
*Washington	7.5	2.0
Detroit	6.8	5.4
*Yonkers	6.8	2.1
Chicago	6.6	6.0
Seattle	6.5	5.5
Las Vegas	6.0	9.0
*Boston	5.6	2.6
Richmond	5.3	5.5
*New York	5.0	2.2

*Rent controlled city

Source: William Tucker, *The Excluded Americans: Homelessness and Housing Policies* (Washington: Regnery Gateway, 1990), p. 37.

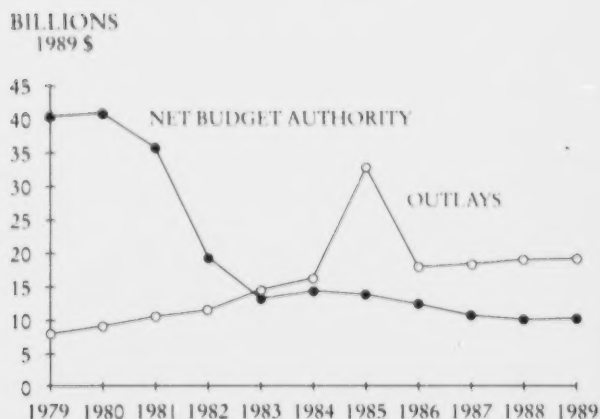
Other researchers challenged the alleged relationship between low vacancy rates and homelessness.¹² Eight of the 17 cities listed did not have rent control or low vacancy rates but relative to the other nine cities had high rates of homelessness. Miami and St. Louis,⁷ for instance, had the highest rates of homelessness among all cities studied but had vacancy rates of 7.0 and 8.5 percent, respectively. While rent control and low vacancy rates may have contributed to homelessness in the nine cities, other factors accounted for homelessness elsewhere.

It is an oversimplification to attribute the complex causes of homelessness to a single factor. Although little is known about where families lived prior to becoming homeless, presumably the nationwide shortage of affordable housing is one factor that precipitated their deprivation. The increase in the number of poor families from 5.3 million in 1978 to 6.9 million a decade later and their declining average real income intensified competition for affordable low-rental housing. Families are the primary recipients of federal rental housing assistance but in 1987 less than three out of ten renters below the poverty level received federal rental assistance.¹³ Almost one million families are on waiting lists for federal rent subsidies and nearly the same number are on waiting lists for public housing.¹⁴ Reagan administration policies may have indirectly increased competition in the low-rent market by retrenching on new rental commitments and by sharply cutting down on subsidized new construction units.

It is par for the course that an assessment of federal housing assistance for low-income families and individuals

would be subject to controversy. It depends whether the analyst focuses on the half empty or half full glass. Viewing annual outlays and the number being assisted, federal aid continued to expand during the past decade. However, annual appropriations tell only part of the story when expansion of housing assistance is measured. To provide aid to renters and homeowners Congress has authorized appropriations to run over multiple years, even several decades. These long-term authorized appropriations have contributed to the expansion of assisted householders. Since 1979 Congress sharply reduced annual net new housing commitments for renters from 334,000 to 99,000, and shifted support from construction outlays to less costly rental assistance in existing stocks. The addition of previously authorized units enabled the federal government to increase between 1979 and 1989 the number of total assisted renters by two-thirds, while net budget authority appropriation during the same period declined by nearly four-fifths and annual outlays for housing more than doubled (figure 2). Presumably, if the earlier incremental commitments remained at pre-1980 levels the stock of affordable housing units would have risen at a higher rate than it did during the past decade. Amid rising construction costs and a mounting budget deficit, the federal government reduced its support for constructing low-rent properties. Between 1979 and 1989 federal commitments for new rental construction units declined by 87 percent (table 2).¹⁵

Figure 2. Outlays for rental assistance more than doubled during the 1980s but net budget authority declined sharply.



Source: U.S. Congress, House of Representatives, Committee on Ways and Means, 1990 *Green Book* (Washington: U.S. Government Printing Office, 1990), pp. 1311-1313.

TABLE 2. Net new construction commitments for rental units declined sharply while the number of assisted renters increased.

Year	Net new commitments for rental construction	Total assisted renters (thousands)
1979	231,156	2,654
1980	155,001	2,895
1981	94,914	3,012
1982	47,618	3,210
1983	23,861	3,443
1984	36,719	3,700
1985	42,667	3,887
1986	34,375	3,998
1987	37,247	4,175
1988	36,456	4,296
1989	30,049	4,402

Source: U.S. Congress, House of Representatives, Committee on Ways and Means, 1990 *Green Book* (Washington: U.S. Government Printing Office, 1990), pp. 1311-1313

Single Men

For decades single room occupancy (SRO) hotels had filled a significant part of the affordable low-rent market. Located in central cities near downtown business districts, SROs had been a source of low-rent private rooms (kitchens and lavatories are usually shared) at daily, weekly or monthly rates. They have traditionally served poor single casual laborers, impoverished elderly and persons with chronic mental illnesses or habitual substance abusers. During the 1970s the number of SRO units declined substantially. The Census Bureau does not process data on SROs or similar quarters but the decline of SROs is well documented.

Gentrification, downtown renewal and tight real estate markets are the likely culprits accounting for the decline in the supply of SROs. In the late 1970s and early 1980s decaying downtowns experienced a rebirth, eliminating many skid rows and other marginal low-rent neighborhoods hovering on their fringes. For example, between 1970 and 1982 Manhattan's SRO stock declined from 110,000 to 18,000 units. New York City fueled this development by offering tax subsidies to landlords converting SROs into apartments. New York City's experience was not unique. Other cities experienced similar losses of SROs.

Chicago	18,000 units
Seattle	15,000 units
San Francisco	5,700 units
Portland	1,700 units
San Diego	1,250 units
Cincinnati	875 units

Public action has reprieved or retrieved SROs in some cities. In 1985 New York City imposed a moratorium, seeking to halt the decline in its remaining SRO stock, but in 1989 the state's Court of Appeals ruled the New York City ordinance unconstitutional. The city intends to build 5,000 units by 1992, but that will make up for only a fraction of the losses experienced in the 1970s. In Los Angeles 1,100 skid row units have been renovated since 1984 by a city-funded nonprofit housing developer. Halting efforts have also been made in San Francisco, San Diego and Portland.¹⁶

Substantial support at all government levels will be needed if SROs are to make a comeback strong enough to counteract market forces. Lack of federal support for SROs has contributed to the current state of homelessness. In an apparently misguided effort to improve the housing quality for the poor, the federal government required that subsidized housing units contain private kitchens and baths, thus effectively excluding SROs from housing assistance programs.

The Mentally Ill

The National Institute of Mental Health estimates that 2.5 million persons in the United States have disabling chronic mental illnesses, including schizophrenia and other psychoses, severe depression and manic-depression. These illnesses often limit a person's ability to live independently and to cope with change. Depending on the severity of their illness and their receptivity to treatment, many mentally ill persons struggle with their illnesses over a lifetime. Long-term treatment, rehabilitation and support are usually needed to help sustain a person during psychotic or depressive episodes. This includes not only mental health treatment but income, housing and social services tied together by integrated case management, which should assume the responsibility of assisting the mentally ill individual to obtain a needed combination of services from diverse sources.

Until the 1950s the chronically mentally ill commonly lived in state and county mental hospitals, but thereafter the number of inpatients in state mental hospitals declined steadily:

Year	Number of inpatients
1955	558,900
1961	527,500
1971	309,000
1981	125,200
1986	111,100

Given the widespread incidence of homeless persons with mental illnesses, deinstitutionalization—the mass discharge of mentally ill persons from institutions into the community—has been a major cause of homelessness. Accompanying deinstitutionalization was a simultaneous policy of “noninstitutionalization” which kept the postwar generation of mentally ill persons out of hospitals when possible. However, the deinstitutionalization movement began more than 30 years ago, but the homeless mentally ill did not appear en masse until the early 1980s. One immediate factor precipitating their homelessness must be sought in the sharp loss of SROs and cheap rooming houses during the 1970s and early 1980s. Although loss of housing is the central factor in explaining the homelessness of the mentally ill, it is unlikely that so many would have become homeless had an adequate system of care for them been in place upon discharge from the hospitals. The deinstitutionalization movement failed to develop such a system. A critical analysis of this failure is a prerequisite to addressing the problems of the homeless mentally ill. Commenting on this experience Senator Daniel Patrick Moynihan of New York wondered, “Whatever became of our capacity to govern ourselves?”¹⁷

Community mental health centers. A number of circumstances fueled the movement away from long-term hospitalization of the mentally ill. The development of antipsychotic drugs in the 1950s raised hopes that community treatment would replace at considerable savings the substandard conditions associated with hospitalization. In 1955 New York State decided to provide tranquilizers to all patients in mental hospitals. Promising effective community treatment and a less costly alternative to hospitalization, Congress passed the Community Mental Health Centers (CMHC) Act of 1963 to finance community-based treatment of mentally ill persons in lieu of hospitalization. Each CMHC receiving federal construction grants assumed an obligation to provide for 20 years inpatient and outpatient services, daytime treatment at hospitals (including consultation and education services), and 24-hour emergency services. The act's goal to cut in half the number of persons in institutions within 10 to 20 years was more than accomplished, but not the promised assistance and the establishment of 2000 CMHC facilities—less than 800 facilities exist today. Consequently, lack of access to CMHC facilities is a major gap in providing adequate care for the chronically mentally ill. Only half of the U.S. population lives in communities with functioning though not necessarily effective CMHCs.

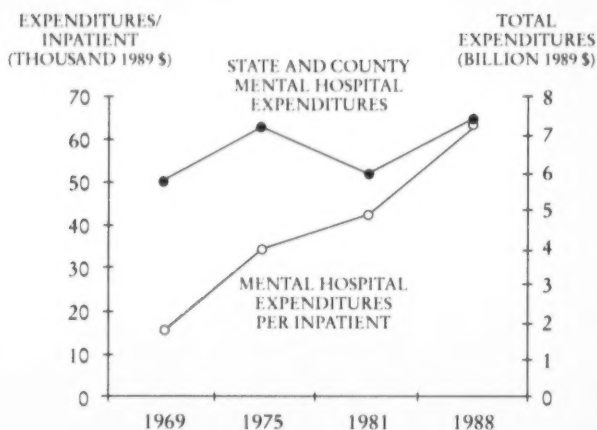
The 1963 CMHC Act provided states the opportunity to shift the costs of caring for the mentally ill onto federal and local governments. Federal cash and in-kind benefits were supposed to ease the transition from mental institutions to living in the community. Mentally ill residents living alone or in adult homes receiving supplemental security income (SSI) and social security disability insurance (SSDI) are also eligible to receive food stamps and medicaid, but those aged 22 through 64 living in community-based supportive group housing are not eligible for medicaid. Adult homes provide living facilities and three meals, but scant care, while group housing is supposed to provide round-the-clock professional supervision, therapy, job training and other needed services.

Given numerous funding spigots and the multitude of recipient agencies, tracking public spending allocated for the mentally ill is extremely difficult. One study estimated that in 1963 states paid 96 percent of the total bill for the mentally ill, with the remaining four percent split evenly between the federal and local governments. By 1985 the state share had decreased to 53 percent of total spending, while the federal share increased to 38 percent and the local share to 9 percent.¹⁸

The states' commitment to CMHCs matched the federal government's lackadaisical efforts. When Congress passed the CMHC legislation it assumed that state mental hospital funding would be redirected to the CMHCs, but made no provisions to ensure that the implied arrangement would be implemented and the states did little to maintain their responsibility for the mentally ill. Health care inflation ate away any savings anticipated by states from hospital closings. Some hospitals were unable to achieve staff cuts proportional to discharged patient loads, thereby increasing staff/patient ratios and expenditures per patient. This may have improved the quality of care, but left no savings to invest in CMHCs (figure 3). Some hospitals continued operations even when inpatient populations warranted hospital closure. While the caseload of mental hospitals declined sharply, caring for the mentally ill became an increasing burden of many general hospitals.

The CMHC legislation failed to design an effective system of caring for the mentally ill. The legislation shifted sole responsibility for the mentally ill from the states to all three levels of government without mandating centralized responsibility for providing needed services. The most detrimental outcome of this policy was that state mental hospital patients were normally discharged into the community

Figure 3. Adjusted for inflation, expenditures for state and county mental hospitals rose by a fifth between 1969 and 1988, but expenditures per patient more than quadrupled (selected years).



Source: U.S. National Institute of Mental Health, Public Health Service, "Mental Health, United States, 1987" (updated).

without arranging for CMHCs to assume responsibility of caring for the discharged patients. Many were "lost" to the system entirely. Dependent upon a fragmented social service delivery system, the mentally ill or their families were obliged to shuffle from one agency to another in search of income support, health care, housing, rehabilitation and other services. Such fragmentation is a frustrating obstacle for all citizens who encounter it, but is an insurmountable barrier for persons whose mental illnesses leave them unable to master the maze of bureaucracies. In the opinion of one mental health professional: "The chronically mentally ill person can't use the current mental health system because it's oriented towards people who have motivation, who have the capacity to develop insights, to change behaviors, [and] to accommodate through socially acceptable behavior."¹⁹

Involuntary commitment and treatment laws. Growing concern for the civil rights of the mentally ill led in the late 1960s and 1970s to the liberalization of state statutes and court decisions governing involuntary commitment and treatment. Before deinstitutionalization involuntary commitment was based on the presumed societal obligation of providing the mentally ill custodial care and treatment. Their civil rights were not at issue. In the 1960s civil rights advocates, armed with exposures of the deplorable conditions in state mental hospitals, launched successful campaigns to place the civil liberties of the mentally ill, including the right to refuse treatment, above the states' and probably many patients' interests in providing or receiving care and treatment.

Beginning with California's Lanterman-Petris-Short Act of 1968, states overhauled their statutes governing involuntary commitment of persons with mental illnesses. The prevailing practice became that the mentally ill could be confined only if their condition presented a danger to others or themselves. A 1972 landmark Wisconsin case (*Les-sard v. Schmidt*), ruling that the burden of proof rests with the state in determining that in the absence of confinement a person poses a serious threat to himself or others, served as a model for challenging involuntary commitment statutes. Currently involuntary commitment is subject to stringent judicial or clinical reviews and other procedural safeguards.

"Right to refuse treatment" rulings advanced the notion that individual liberty, however exercised, normally takes precedence over treatment [*Rogers v. Okin* (1979 Massachusetts) and *Rennie v. Klein* (1981 New Jersey)]. These rulings maintained that involuntarily hospitalized mentally ill persons could refuse antipsychotic medications. Half the states now permit patients to refuse medication.

These legal developments granted the mentally ill civil rights which they were previously denied, but have raised concerns that persons with serious manifestations of mental illness have been left "rotting with their rights on."²⁰ Arguments that persons with severe mental disorders be allowed to "choose" their debilitating existence ignores the fact that some disorders incapacitate a person's ability to exercise reasoned judgment and that persons with severe mental disorders may be unable to function in the community. Asylums are a vital component in a system of care for the mentally ill. Well-intentioned as they may have been, civil rights rulings ignored this reality. These legal developments permitted the mentally ill to be dumped into communities without adequate resources to care for them. Several states place mental patients discharged from hospitals in halfway houses. The transfers normally involve considerable savings, but the care provided for the discharged patients is frequently substandard. For example, New York State houses some 9000 discharged patients in adult homes. All these facilities provide is room, three meals and minimal medical care. At an average annual cost of \$9000 per resident the savings to the state are considerable, but an investigation by a state commission found that many of the residents live in "wretched conditions." An operator of an adult facility rationalized the dilapidated and unsanitary conditions: "We can't be a five-star hotel on \$24 a day."²¹ In the 1980s New York State financed a limited number of group homes, housing normally no more than a dozen residents, which provided in addition to basic needs supervised professional assistance at

an annual cost per resident nearly three times as high as adult homes.²²

Adequate care for mental patients, whether housed in the community or in hospitals, is costly. A well-funded and integrated community-based system of care providing for varying levels of independence would offer more than hope to many and its development should be encouraged within affordable means. But others, including some whose condition relapses because they refuse medication, are too ill to function in a community setting.

Unless dangerous enough to warrant involuntary commitment, untreated persons often relapse into a downward spiral and may become homeless. Mental health professionals observe that the homeless mentally ill become fearful, distrustful and reluctant to enter shelters or transitional housing. Aggressive outreach programs in which teams of social workers and volunteers build trust with homeless persons over a period of days or months are being demonstrated in some areas as a way to encourage homeless persons to receive services. Although a promising approach, the intractable difficulties faced by some mentally ill raise questions about the effectiveness of outreach programs even if funds were available to expand these services on a broader basis. Experts agree that an undetermined percentage of the mentally ill need long-term hospitalization. Involuntary commitment and treatment practices need to be modified to provide, with appropriate legal safeguards, needed asylum and treatment.

The failure of CMHCs to provide a caring alternative to mental institutions for persons with serious mental illnesses led the National Institute of Mental Health (NIMH) to establish in 1977 pilot community support programs (CSP). Since then NIMH has awarded research grants—\$28.6 million in 1990—to test ways to coordinate the array of services and supports needed for the chronically mentally ill person to function in the community. In the late 1980s about half of CSP demonstration funds have been directed towards the homeless mentally ill. Backed with positive findings from the community support program, Congress enacted in 1986 the State Comprehensive Mental Health Services Plan Act. In order to receive federal mental health funds states are now required by the federal government to develop plans for implementing community-based systems of care for the seriously mentally ill. Congress failed to indicate how plans without added resources would help the mentally ill.

Given the high health costs of caring for the mentally ill and rising health care spending, Congress is unlikely to

step up long-term funding for the seriously mentally ill, and states are not likely to resume widespread responsibility for housing them in hospitals. In the absence of a national political consensus to provide comprehensive services to the mentally ill, the burden of caring for them is now left to states and localities with whatever assistance is available from the federal government.

Other nations also adopted similar practices of deinstitutionalizing the mentally ill. Great Britain has followed a policy parallel to the United States with respect to the mentally ill. In the 1950s and 1960s it released some 90,000 patients from mental hospitals. Like the U.S., Great Britain failed to provide alternative care in the community, creating a demand to return to the old practice of asylum. A recent British government white paper recommended retaining the asylums that remain open and the *British Medical Journal* favored the "rehabilitation of the mental hospital."²³

FEDERAL ASSISTANCE

Congress first debated the federal responsibility for homelessness during the 1981-82 recession when the media focused attention on the phenomenon of homeless individuals and families. No longer "skid row bums," the new homeless were presumably the working poor and those recently forced into idleness, casualties of widespread economic dislocation reminiscent of the Hooverville inhabitants during the Great Depression.

In 1983, when national unemployment remained at 9.6 percent (only 0.1 percent lower than the record post-World War II rate in 1982) Congress passed an emergency jobs bill. The legislation included an appropriation of \$100 million for emergency food and shelter for the homeless. To distribute the funds Congress established a national board made up of representatives from six charitable and religious organizations (the Red Cross, Salvation Army, United Way, Catholic Charities, Council of Jewish Federations, and National Council of Churches), headed by the director of the Federal Emergency Management Agency (FEMA). This unconventional administrative arrangement, relying upon private organizations to distribute federal funds, reflected the belief that homelessness was a temporary consequence of the recession and that existing organizations could distribute the funds effectively and expeditiously through their networks of local chapters and nonprofit organizations that operated most services for the homeless.

Although the Reagan administration favored a "hands-off" approach and refused to acknowledge federal

responsibility for rising homelessness, it offered no opposition to the program. In keeping with the Reagan philosophy, the emergency food and shelter program promoted "public-private partnerships," kept federal involvement to a minimum, and persisted with the ideology that caring for the homeless was a local responsibility. However, to send a signal that it "cared," the Department of Health and Human Services set up in 1984 a task force charged with coordinating and targeting existing federal and private resources to aid the homeless. But the task force accomplished little. Its activities were largely limited to publishing a resource guide for community organizations describing model homeless programs, providing technical assistance and submitting a briefing paper to Congress listing existing federal programs that might be used to fund services for the homeless. The task force also secured formal agreements with federal agencies, including the Department of Housing and Urban Development, Defense Department and the General Services Administration, committing surplus food or property held by these agencies to shelters and soup kitchens, but little was tried and less was accomplished.²⁴

Homelessness persisted and may have even risen during the prolonged economic recovery, intensifying pressures to alleviate the deprivation of the homeless and to increase federal support. Constrained by rising federal deficits and lacking an understanding of the causes, nature and extent of homelessness, Congress responded cautiously by appropriating \$325 million between 1984 and 1987 to support the Federal Emergency Management Agency's ongoing emergency food and shelter program. It also required public assistance agencies to deliver federal benefits to eligible homeless persons by setting up outreach programs at homeless shelters and allowed the homeless to pick up benefit checks at local agencies.

The McKinney Act

Acknowledging that homelessness is a pressing and lasting national problem, Congress passed in 1987 the Stewart B. McKinney Homeless Assistance Act and appropriated \$490 million that same year to be spent on providing services and temporary shelter for the homeless. It took bipartisan support to overcome administration opposition and its insistence that homelessness should be addressed by state, local and private sector initiatives without additional federal appropriations. The House bill initially authorized \$100 million to provide 4,000 HUD rental subsidy certificates to homeless families. However, House-Senate conferees deleted this provision, signaling that renewed federal support for low-income housing was not to be.

Annual appropriations for the McKinney Act have fluctuated since its inception, as follows:

1987	\$490 million
1988	267 million
1989	400 million
1990	597 million
1991 (preliminary)	655 million

In contrast to his predecessor's actions, President Bush proposed expanding McKinney funding for 1991 to \$749 million, \$150 million above the amount Congress appropriated for 1990 and \$22 million in excess of the amount it authorized for 1990.

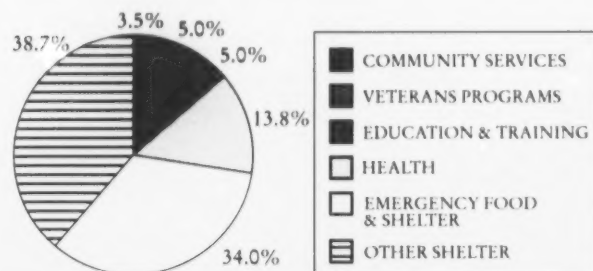
Although the passage of the McKinney Act signaled congressional recognition that homelessness is a persistent problem, the law stressed temporary relief measures and failed to provide for an integrated administration of its multiple disparate though related programs. Probably the inclusion of the aforementioned task force as part of the new legislation best illustrates the scattered responsibility designed by Congress for the administration of the McKinney Act, representing a Rube Goldberg vision of managing a complex piece of legislation. Upon transfer to the McKinney Act, Congress upgraded the task force to the Interagency Council on the Homeless. Congress assigned the Council, which includes representatives from 15 federal agencies, the responsibility of coordinating federal assistance for the homeless. A wag defined coordination as an unnatural act between unconsenting adults. Chaired by the Secretary of HUD, it is not surprising that the Council remained largely dormant under Secretary Samuel Pierce. It took a court order requiring the Council to carry out its mandate. Secretary Jack F. Kemp took steps to activate the Council but the attempt to coordinate the activities of 15 separate agencies proved to be a frustrating task, although a General Accounting Office report found that the Council became more effective under Kemp's stewardship. Having praised the activities of the Council under Secretary Kemp, the GAO found, "Three years after [the enactment of the law] there is still no comprehensive federal guidance on how to obtain federal vacant properties."²⁵

A major function of the Council is to lease surplus government-held property to assist the homeless. As of mid-1990, HUD had reviewed 7666 properties that might be leased to assistance providers, but the agencies involved had approved only 13 leases and another 19 were still being processed. While the GAO found numerous obstacles to the transfer of unutilized properties, it failed to recognize the

inherent difficulty of implementing a program that involves 15 separate department or independent agencies.

Similar administrative problems plague the rest of the McKinney provisions. Seven departments or agencies—the Federal Emergency Management Agency and the Departments of Housing and Urban Development, Health and Human Services, Labor, Education, Agriculture, and Veterans Affairs—are responsible for implementing 17 separate programs providing in addition to the emergency food and shelter program funded since 1983, a range of services including community mental health services, supportive housing, psychiatric care, education and job training (table 3 and Appendix). Demonstration projects for AFDC families and education programs for homeless children focus on the special needs or circumstances of the mentally ill, veterans, and families with children (figure 4).

Figure 4. Distribution of 1990 McKinney funds.



Source: U.S. Department of Housing and Urban Development

TABLE 3. Three of every four dollars appropriated under the McKinney Act are allocated for food and shelter (1990).

Program	(millions)
<i>Total</i>	\$597.1
<i>Shelter</i>	434.1
Emergency food and shelter	130.1
Emergency shelter	73.2
Supportive housing demonstrations	126.8
Supplemental assistance	10.8
Section 8 SROs	73.2
AFDC demonstrations	20.0
<i>Health</i>	82.4
Health services	32.4

(cont. on page 27)

Community mental health services block grant	27.7
Community mental health demonstrations	6.0
Community alcohol/drug abuse treatment demonstrations	16.3
<i>Community Services</i>	
Emergency community services	20.9
<i>Education and Training</i>	
Job training and veterans' reintegration demonstrations	11.3
Homeless adult education	9.9
Education for homeless children and youth	8.5
<i>Veterans</i>	
Psychiatric treatment for chronically mentally ill veterans	15.0
Domiciliary care	15.0

Note: An appendix contains brief descriptions of the listed programs.

Source: U.S. Department of Housing and Urban Development

The 17 programs do not exhaust federal assistance for the homeless. For example, the list does not include the runaway and homeless youth program authorized under separate legislation. The temporary emergency food program is another program that may help the homeless. In fiscal 1989 Congress earmarked \$40 million to fund soup kitchens and food banks. However, according to the Congressional Research Service the majority of the beneficiaries were not homeless.²⁶ The homeless are also entitled to public housing or rental assistance under Section 8, but the extent to which the homeless benefit from these programs is unknown. Given the length of waiting lists, probably few homeless obtain the available slots unless they are given priority over previous applicants.

A report prepared by the Interagency Council on the Homeless listed over 60 programs available to help the homeless.²⁷ No doubt some homeless might have benefited from the array of programs, but since the list includes a program designed to stimulate entrepreneurship the loose inclusiveness of the programs becomes suspect. The home-

less are not likely to include many entrepreneurs. With some isolated exceptions, it appears that unless assistance is targeted on the homeless other eligible claimants normally receive preference. Lack of residency alone presents severe obstacles.

Avoiding controversy over renewing federal subsidies for affordable rental housing for the poor, Congress beefed up several existing programs and authorized a handful of demonstration projects to provide services and shelter to the homeless. The emergency shelter and emergency community services programs parallel the existing community development and community services block grants. The McKinney Act earmarked additional funds for the homeless under existing community mental health and alcohol/drug abuse treatment demonstration programs administered by the Department of Health and Human Services.

Recognizing the importance of expanding SROs to aid the homeless, the McKinney Act provided for a very modest expansion of SROs. Under the Section 8 SRO program, HUD provides long-term rental assistance payments to landlords on behalf of homeless individuals renting units in rehabilitated SRO projects. Since 1987 Congress has appropriated \$153 million for the program, which HUD has used to finance 2328 SRO units over ten years at an average annual outlay of about \$3,600 per unit—enough to help less than one percent of the homeless.²⁸ SRO projects financed by the program often provide support services, including counseling, mental health and outpatient health services, transportation, and money management.

The supportive housing program funds permanent group housing and services for homeless persons with mental and physical disabilities. Since its inception the program has helped an estimated 500 homeless persons, a tiny fraction of the total disabled homeless population.

The impact and effectiveness of the total McKinney funding is unknown. The restrictive nature of the categorical funding militates against sound implementation. The McKinney programs are a jumble of competitive and formula grants awarded to state and local agencies as well as nonprofit organizations, precluding integration of funded services.

Service providers argue that the existing funding arrangements of the Act's three shelter programs (emergency shelter, supportive housing and supplemental assistance programs) deny communities flexibility to tailor their operations to their widely varying needs. For example, com-

Supplemental Emergency Assistance

munities with adequate emergency shelters but in need of supportive housing or social services are unable to make use of the emergency shelter funds yet are not automatically eligible for supportive housing and supplemental assistance demonstration funds. Having failed to agree upon allocation formulas, Congress narrowly defeated a proposal to incorporate these three programs into a block grant. In 1990 Congress reached a truly Solomonian decision. The solons agreed that the three programs would be consolidated into a block grant subject to reaching in advance a formula for the allocation of funds.

In addition to the regular benefits paid to families receiving AFDC, federal law allows states to make additional payments to families facing emergencies. In 1989 the emergency assistance program totaled \$308 million and served an average monthly caseload of 49,000.²⁹ Nearly half the states have deemed homelessness or pending eviction to be emergencies and provide temporary housing and support services for homeless families or pay back rent for those faced with eviction. While it is generally recognized that measures to prevent homelessness are cost-effective compared with emergency assistance offered after homelessness ensues, the U.S. General Accounting Office could not find data to assess the effectiveness of preventive measures.³⁰

Eight jurisdictions, most notably New York City and the District of Columbia, have used emergency assistance (EA) funds for housing and providing support services to homeless families in "welfare hotels." Some homeless families have lived for months and even years in decrepit hotels that often charge as much as \$2,000 per month for a room, a cost shared evenly by federal and local or state governments. HHS charged that states and localities have violated the EA regulations, which restrict emergency assistance to a 30-day period during a year. HHS and Congress have clashed over the interpretation of the law's 30-day emergency period. At issue is whether EA funds can be used for payments preceding a family's emergency or for expenses following the emergency. For example, can EA funds be expended to pay several months of unpaid back rent that threatens a family's eviction or to pay for temporary housing following the onset of homelessness? Opponents argue that the 30-day restriction fails to recognize the true needs of troubled, multi-problem, homeless families seeking assistance. Limiting EA to 30-days, according to this argument, would preclude any chances of rehabilitating these families.

HHS has attempted since 1987 to restrict the use of EA funds to one 30-day period within a year and to provide for needs occurring during that 30-day period only. But faced with the continued presence of homeless families, Congress has placed moratoria on the proposed restrictions—the latest expired as of September 1, 1990—allowing states to expend EA funds for temporary housing and services over periods exceeding 30 days. Congress has failed to face up to the consequences of its compassionate actions, as the continued moratoria raise concerns that the long term use of EA funds to pay back rent could induce families to become delinquent in their rent payments.

In addition to EA payments, states may augment AFDC benefits to cover families' "special needs." A minority of the states have provided additional support to cover the expenses of emergency housing for homeless families or high-priced housing in expensive real estate markets. Aggregate outlays for special needs are not available.

THE COSTS OF A COMPREHENSIVE PROGRAM

The homeless need help. However, the high costs of expanding housing assistance and providing needed services have prevented a consensus on a comprehensive national program in aid of the homeless. New York City's expenditures illustrate the magnitude of the costs involved in providing only emergency aid, let alone permanent housing and services to the homeless nationwide. In 1988 New York City spent \$758 million—half contributed by the federal and state governments—to care for over 30,000 persons, compared with the McKinney Act's average annual appropriation of \$424 million during its first four years. Assuming that New York City accounts for a tenth of the nation's homeless—it represents three percent of the total population—the cost of a national emergency program for the homeless would amount to at least \$7.5 billion.

Only crude estimates can be made about the total price tag entailed in providing permanent housing and services for the homeless, including hospitalization for the homeless mentally ill requiring institutionalization. Even under conservative assumptions about the number of beneficiaries and the level of assistance, the costs would be substantial. Whether providing affordable low-rent housing is best achieved through rehabilitation, construction or rent subsidies is endlessly debated among housing experts, but a mix of all three is probably necessary. In 1990 the federal government estimated that the cost of subsidizing a tenant for one year in an SRO unit would amount to \$3,670, for a

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total of \$1.6 billion (assuming 425,000 homeless single persons). Subsidizing 75,000 homeless families through HUD's Section 8 certificate/voucher programs at an annual cost of \$5,500 would require an additional \$412 million.

The homeless who are able to work need to be induced to undertake extensive education and job training to prepare them for economic self-sufficiency. The number of homeless persons who could potentially benefit from job training programs is not known. Using outlays under the federal Job Training Partnership Act as a guide, the cost per placement according to the Labor Department is about \$4,700 involving an annual outlay of \$470 million (assuming 100,000 homeless could be trained). Funding public service jobs—cleaning up parks and streets where the homeless live—would benefit communities and increase public sympathy for the plight of homeless people, but would entail additional outlays. Creating full-time jobs at the minimum wage for 25,000, including minimal administrative outlays, would cost in excess of \$300 million.

- The homeless mentally ill also need supportive group
- housing with services tied together by case management, and some require hospitalization. Case management costs for the mentally ill vary widely depending upon the level of services provided and the case manager's caseload, but some research suggests average annual costs of \$5,200 per person.³¹ To provide case management services for 100,000 homeless persons would require \$520 million a year. Hospitalization of 50,000 severely mentally ill homeless at an annual cost of \$50,000 per individual would add another \$2.5 billion to the cost of the program. Of course, most hospitals would resist institutionalizing mentally ill persons for more than a few weeks, consequently few would be cured. The least that the homeless mentally ill would need is to be housed in group facilities at an annual cost of \$25,000 or more, and some will return before long for additional hospital treatment. A significant proportion of the homeless need drug abuse treatment which would be essential if they were to be rehabilitated. The cost per treatment would vary widely depending upon the treatment offered.

These crude estimates suggest that the price tag for a comprehensive program to aid the homeless would entail an annual outlay of nearly \$6 billion. And these estimates do not include a needed multibillion initial investment. The homeless are one group among many who lay claim to government assistance.

PROSPECTS DURING THE EARLY 1990S

High costs are likely to inhibit adequate and sustained help for the homeless. If opinion polls reflect public sentiment, it appears that an increasing number, though still a minority, of Americans are ready to blame the homeless for their plight. According to a May 1990 Washington Post/ABC poll, 63 percent of Americans thought that the homeless are victims of "circumstances beyond their control" compared with 75 percent who held the same view in September 1989. The same survey found that respondents willing to pay more to assist the homeless had declined to 58 percent compared with 71 percent eight months earlier.³² The courts are presumably responsive to election results; they may also heed the polls. In May 1990 the Second U.S. Circuit Court of Appeals held that free speech claims do not apply to the rights of panhandlers in New York City subways. A single court decision does not make a trend, but reports of police actions in several cities indicate that the civil rights won by the homeless during the past three decades are being ignored by law enforcement agencies. In 1984 the District of Columbia voters approved overwhelmingly an ordinance making overnight shelter an entitlement; six years later the City Council limited the right to shelter (a step subsequently endorsed by District voters).³³

Homelessness is not a top priority of either the Bush administration or Congress. The Bush administration and Congress have proposed support for a modest expansion of McKinney efforts on behalf of the homeless. President Bush favored boosting the 1991 McKinney Act appropriations by \$150 million in excess of the amount appropriated for the preceding year, but the final increase was only about a third of this amount. Omnibus housing proposals introduced by the Bush administration, Senator Cranston and Representative Gonzalez during the 101st Congress would expand some assistance to the homeless, but supply little direct long-term help.³⁴ Their good intentions became another victim of budgetary constraints, when the Senate and House conferees meet to iron out the differences between the bills approved by each house.

The McKinney SRO demonstrations might induce a renewal of investments in SROs, and the Bush administration has taken steps to make Federal Housing Administration (FHA) mortgage insurance available to SRO developers. However, without additional subsidies by budget-strapped local governments, FHA backed SROs may not be within reach of homeless singles. The low-income rental housing tax credit provides investors a tax credit for each low-income rental unit they develop. Due to expire this year, the tax credit remains virtually the only tax incen-

tive for developers to invest in rental housing for the poor. In addition, some 300,000 tenants whose rents are subsidized under a federal mortgage program are in jeopardy of losing their shelter. Two decades ago the federal government subsidized housing developers on condition that they rent to low-income households at reduced rates. The law allowed the private developers to pay off their 40-year mortgage after 20 years, freeing the owners from any obligation to low-income renters. Unless Congress acted many of these units now occupied by low-income renters may be gentrified, leading to more homelessness because the low-income renters may not find affordable housing.³⁵ The pending Senate bill would place obstacles, though not prevent, owners from paying off their mortgages. The Senate bill would have prevented prepayment in tight low-income housing markets. In contrast, the House relied upon incentives to encourage owners to continue renting to low-income renters, but owners could choose not to accept the incentives. Nonprofit organizations would be given the right to buy the property at its appraised fair market price. If no qualified buyers come forth, the owners could evict the tenants after an interim period. The House version may result in loss of affordable housing stock available to low-income renters. As finally enacted, the law sharply restricted the rights of owners to pay off their mortgages.

Government intervention would also be necessary to counteract ever-prevailing NIMBY ("not in my backyard") tensions generated by the development of SROs or housing for the mentally ill. In August 1990 New York State and New York City agreed on funding 5,225 SROs within two years. Advocates of the homeless praised the decision but cautioned that opposition from communities will constitute a major obstacle to implementing the plan.³⁶ It is unlikely, therefore, that communities would support a significant expansion of SROs in the foreseeable future, even if funding were available. Similarly, some communities have tried to assign priorities to the homeless in vacated public housing, but objections from public housing tenants have prevented implementing such policies.

The past decade showed the Reagan administration to be a passive player in the face of discriminatory housing development patterns. Whether the Bush administration will choose to take an active role in counteracting local opposition remains to be seen. HUD Secretary Jack Kemp seems to favor policy changes. Commenting on a related problem, he declared, "I've taken a lot of heat for trying to target block-grant money to the poor. Some of my bleeding heart liberal mayors object."³⁷

The homeless have failed to benefit from programs for which they are eligible. An aggressive outreach program would help. However, the potential should not be overstated. Many homeless are not in a position to participate in programs designed to help the poor, and as far as non-entitlement assistance is concerned greater participation by the homeless is likely to involve robbing Peter to pay Paul. There are many potential clients for non-entitlement funds and expanding the demand would not add to the total number of needy persons being helped. Allocating more housing units to the homeless without adding additional units would necessarily deny subsidized housing to other needy households who may have waited for years to gain access to public housing. Similarly, using more community service block grants or similar programs to help the homeless, as a 1989 Health and Human Services report suggested, would add clients to already underfunded programs.

A potentially more promising strategy even with current appropriations, is to utilize more efficiently existing resources by overhauling the fragmented welfare system. The reforms should begin with Congress where several committees claim jurisdiction over McKinney Act programs. The most obvious solution would be to centralize jurisdiction over McKinney Act programs in one committee. One significant precedent for this approach can be found in the administration of President Johnson's antipoverty efforts. At the executive branch Congress established an agency within the office of the president for administering the diverse programs that were normally within the turf of several departments and independent agencies. HUD has made halting steps in that direction. With the cooperation of the Robert Wood Johnson Foundation the department is supporting demonstration projects in eight cities designed to integrate health and supportive services for homeless families. In order to qualify for a grant each jurisdiction had to designate a single agency that will take the lead in serving homeless families.¹⁸

"ADJUSTING" TO HOMELESSNESS

Homelessness has become highly visible during the past decade, but compassionate attitudes towards the homeless appear to be on the wane. The costs of making significant dents in homelessness are high, the problems of many homeless appear to be intractable and public demands to address other social concerns are pressing. A concerted, expanded attack to reduce homelessness in the foreseeable future is not in the cards.

More money is needed to deal effectively with the festering paradox of homelessness in the United States. But a realistic and comprehensive program will also require a reexamination and assessment of the civil rights accorded to the mentally ill and substance abusing homeless. Addressing their real needs may involve infringements of their civil rights and require involuntary institutionalization of some mentally ill. The implementation of such programs will not come cheaply. An objective and compassionate appraisal of the rankling homelessness phenomenon must recognize their total needs and require an overhaul of the fragmented and wasteful welfare system. Additional funding would alleviate their deprivation, but a comprehensive program must also deal with the deep-seated afflictions of the homeless and realistically reassess their rights in a truly compassionate society.

APPENDIX: MCKINNEY ACT PROGRAMS

Shelter

Emergency Food and Shelter

Continuing the initial 1983 effort providing direct aid to the homeless, the emergency food and shelter program funds approximately 10,000 nonprofit agencies and charitable organizations in about 2,300 jurisdictions. A national board made up of representatives from the Federal Emergency Management Administration, the Red Cross, Salvation Army, United Way, Catholic Charities, Council of Jewish Federations, and National Council of Churches administer the funds that are distributed according to a formula based on local unemployment and poverty rates.

Emergency Shelter

Administered by HUD, this program primarily funds the renovation, repair or conversion of buildings into emergency shelters and pays for a shelter's operating costs. Up to one-fifth of the funds may be used to provide social services at the shelters, to be raised to 30 percent if a Senate bill prevails. Funds are distributed to state and local governments which, in turn, allocate their funds to nonprofit organizations. The allocation formula for the community development block grant (based on poverty, economic growth and housing conditions) applies to the distribution of emergency shelter funds. Since the program began in 1987, it has provided funds to about 22,000 shelters with a total capacity of about 80,400 beds.

Supportive Housing Demonstrations

HUD provides advances, grants and technical assistance to develop two types of supportive housing: (1) transitional housing providing homeless persons up to two years of housing plus support services to help them live independently; and (2) permanent group housing and support services for homeless persons who are handicapped, including the mentally ill. States, local governments and nonprofit agencies compete for funds which are awarded at HUDs discretion. In 1989 about 5,100 persons were served by the program.

Supplemental Assistance

HUD provides assistance to recipients for innovative projects which address the comprehensive short- and long-term needs of the homeless. Funds are awarded to bidders participating in competition.

Section 8 Assistance for SROs

HUD awards funds through a national competition to local public housing agencies to provide rent subsidies to SRO tenants. In 1989 HUD awarded \$45 million to 25 local public housing agencies to support about 1,200 SRO units.

AFDC Demonstrations

Beginning in 1990 the law authorized HHS to award demonstration grants to three states to rehabilitate or construct transitional housing and provide support services for homeless AFDC families currently housed in "welfare hotels."

Health

Health Services Grants

HHS awards funds on a national competitive basis to local nonprofit agencies providing free outpatient health and substance abuse services to the homeless. In 1989 HHS awarded 109 grants to city health departments, community health centers and social service organizations which coordinate health services through homeless shelters.

Community Mental Health Services Block Grant

Based on the number of people living in urban areas, HHS allocates funds to states for outreach, case management, outpatient treatment of the mentally ill, alcoholics and drug addicts, and supportive housing. States, in turn, pass the funds to community organizations serving the homeless.

Community Mental Health Demonstrations

HHS awards funds through a national competition to states, local governments and nonprofit agencies for programs serving the homeless afflicted with chronic mental illnesses. Funds are to be used to support projects providing a comprehensive and coordinated system of care for the mentally ill. In 1989 HHS awarded funds to 12 projects which served 1,365 persons.

Community Alcohol and Drug Abuse Treatment Demonstrations

HHS awards funds through a national competition to nonprofit organizations serving the homeless. Funds are to be used to support projects demonstrating successful ways to treat homeless persons with alcohol and drug abuse problems. In 1989 HHS funded nine projects.

Community Services

Emergency Community Services

HHS awards community services block grant funds earmarked by the McKinney Act for community action agencies that provide social services to the homeless.

Job Training and Education

Job Training Demonstrations

The Labor Department awards funds through a national competition to states, local governments, nonprofit agencies and private industry councils. Funds may be used to provide the homeless with remedial education, job training, counseling, assistance in finding jobs, and literacy instruction. In 1989 the Labor Department awarded 21 grants for projects in 16 states. As of June 1989, 5,265 persons have participated in the program, with 1,956 enrolled in training and 1,546 placed in jobs.

Homeless Adult Education

The Education Department awards funds to states based on the estimated homeless population in each state. Funds are used to provide literacy and basic skills instruction for homeless adults. In 1989 the department awarded 35 grants.

Homeless Children and Youth Education

According to a formula based on the per capita education spending for poor children, the Education Department awards funds to states to set up state offices to assist homeless children in obtaining access to public education. The Senate bill would expand the program.

Veterans

Psychiatric Treatment for Mentally Ill Veterans.

The Department of Veterans Affairs (DVA) awards funds to its medical centers to provide psychiatric treatment, rehabilitation and outreach to homeless veterans with chronic mental illnesses. According to the latest available data there were 43 projects for homeless veterans.

Domiciliary Care.

DVA has funded 20 medical centers to convert nearly 1000 beds for domiciliary care of homeless veterans with chronic mental illnesses.

Reintegration Program

The Labor Department awards funds to states and localities to provide homeless veterans job training.

ENDNOTES

1. Telephone interview with Cynthia Taeuber, Census Bureau, July 17, 1990.
2. Martha R. Burt and Barbara E. Cohen, *America's Homeless* (Washington: Urban Institute Press, 1989), pp. 27-29.
3. Richard B. Freeman and Brian Hall, *Permanent Homelessness in America* (Cambridge, MA: National Bureau of Economic Research, 1986); ICF, Inc. *Characteristics and Housing Needs of the Homeless* (Fairfax, VA: ICF, Inc., 1987), p. 18.
4. Irving Piliavin and Michael Sosin, "Tracking the Homeless," University of Wisconsin, Poverty Institute, *Focus*, Winter 1987-88, p. 24.
5. Peter H. Rossi, *Down and Out in America* (Chicago: University of Chicago Press, 1989), p. 105.
6. "Survey of Mental Ills and Addiction," *New York Times*, September 10, 1989, p. A36.
7. U.S. General Accounting Office, *Homeless Mentally Ill: Problems and Options in Estimating Numbers and Trends*, PEMD 88-24 (Washington: General Accounting Office, 1988), p. 11.
8. Burt and Cohen, *America's Homeless*, p. 39; Piliavin and Sosin, "Tracking the Homeless," p. 21.
9. Ruth Ellen Wasem, "Homelessness: Issues and Legislation in the 101st Congress" (Washington: Congressional Research Service, IB88070, October 26, 1989), p. 5.
10. Peter H. Rossi, *Down and Out in America*, p. 133; Burt and Cohen, *America's Homeless*, pp. 39-40, 50.
11. U.S. Census Bureau, *American Housing Survey for the United States in 1987* (Washington: U.S. Government Printing Office, 1989), pp. 166-168.
12. Richard P. Applebaum, Michael Dolney, Peter Breier and John I. Gilbertbloom, "Scapegoating Rent Control: Masking the Causes of Homelessness" (Washington: Economic Policy Institute, 1990).
13. U.S. Census Bureau, *American Housing Survey for the United States in 1987*, p. 166.
14. Jill Zuckman, "Little New Aid is Expected Despite Growing Need," *Congressional Quarterly*, April 28, 1990, p. 1268.
15. U.S. Congress, House of Representatives, Committee on Ways and Means, 1990 *Green Book* (Washington: U.S. Government Printing Office, 1990), p. 1309.
16. Gwen Ifill, "Some Cities Reviving SRO Hotels in Effort Against Homelessness," *The Washington Post*, April 21, 1990, p. A3.
17. "Promise to the Mentally Ill Has Not Been Kept," *New York Times*, May 22, 1989.
18. E. Torrey Fuller, *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill* (New York: Harper and Row, 1988), pp. 221-228.
19. Joseph Halpern et al., *The Myths of Deinstitutionalization: Policies for the Mentally Disabled* (Boulder, CO: Westview Press, 1980), p. 52.
20. Paul S. Applebaum, "The Right to Refuse Treatment With Antipsychotic Medications: Retrospect and Prospect," *American Journal of Psychiatry*, April 1988, p. 413.
21. Selwyn Raab, "Mental Homes Are Wretched, A Paper Says," *New York Times*, August 6, 1990, p. B1.
22. Michael Winerip, "For Mentally Ill, An Alternative to Adult Homes," *New York Times*, August 21, 1990, p. B1.
23. "Second Thoughts," *The Economist*, November 25, 1989, p. 69.

24. U.S. Congress, House of Representatives, Committee on Government Operations, *Federal Response to the Homeless Crisis* (Washington: U.S. Government Printing Office, 1984), pp. 205-207.
25. U.S. General Accounting Office, *Homelessness: Changes in the Interagency Council on the Homeless Make It More Effective* (Washington: GAO/RCED-90-172, July 11, 1990); Testimony of John M. Ols, Jr., Director, GAO Housing and Community Development Issues, before the U.S. Senate Committee on Government Affairs, July 19, 1990, p. 6.
26. Ruth Ellen Wasem, "Programs Benefitting the Homeless" (Washington: Congressional Research Service report 89-20EPW, January 6, 1989), p. 6.
27. The Interagency Council on the Homeless, "Non-McKinney Federal Programs," July 1989, p. 28.
28. U.S. General Accounting Office, *Implementation of the McKinney Act* (Washington: General Accounting Office, RCED 89-50, May 1989), p. 77; U.S. Department of Housing and Urban Development, News Release #89-124, September 15, 1989.
29. *1990 Green Book*, p. 567.
30. U.S. General Accounting Office, *Homelessness: Too Early to Tell What Kinds of Prevention Assistance Works Best* (Washington: GAO/RCED-90-89, April 1990).
31. William A. Anthony and Andrea Blanch, "Research on Community Support Services: What Have We Learned," *Psychosocial Rehabilitation Journal*, January 1989, p. 70.
32. Gwen Ifill, "Sympathy Wanes for the Homeless," *The Washington Post*, May 21, 1990, p. A1.
33. Jason DeParle, "Homeless Advocates Debate How to Advance the Battle," *New York Times*, July 8, 1990, p. 14.
34. Jill Zuckman, "Housing," *Congressional Quarterly*, September 8, 1990, pp. 2859-2861.
35. Jill Zuckman, "Housing," *Congressional Quarterly*, June 16, 1990, p. 1886 and August 4, 1990, pp. 2515-2516.
36. Tim Golden, "Cuomo and Dinkins Agree To House 5,225 Mentally Ill," *New York Times*, August 23, 1990, p. A1.
37. Robert Kurtner, "Bleeding Heart Conservative," *New Republic*, June 11, 1990, p. 22.
38. The Robert Wood Johnson Foundation, "The Homeless Family Program" (Boston: The Robert Wood Johnson Foundation), December 1989.